



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

KILLEEN EMERGENCY PHYSICIANS
P O BOX 2283
MANSFIELD TX 76063

Respondent Name

TEXAS MUTUAL INSURANCE CO

Carrier's Austin Representative Box

Box Number 54

MFDR Tracking Number

M4-12-0926-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We filed the original bill to the patient within the 95 days timely filing limit, **per instructions of the patient** at the time of the ER visit. The patient was sent several statements & the account was referred to collection agency We did not receive the correct Workers Compensation information until **07/28/2011 when our office received a letter from Texas Mutual to file claim on a HCFA claim form...**As soon as we received the correct billing information we immediately updated our account and submitted our bill. Our bill has been denied as 'Time limit for filing claim/bill has expired.'..."

Amount in Dispute: \$91.65

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The claimant received treatment at Metroplex Hospital on 12/12/10 through the emergency department. Texas Mutual received the hospital's bill on 1/28/11...Texas Mutual paid the bill. The requestor is the emergency room doctor who provided treatment to the claimant through the Emergency Department at Metroplex Hospital on 12/12/10 then billed Texas Mutual for this on 8/31/11. The Mutual denied payment consistent with Rule 133.20...The requestor submitted a request for reconsideration but failed to provide persuasive mitigating information for the late billing. It failed to explain why it did not have the correct billing information when the hospital had the correct information at least five days prior to 1/28/11. For these reasons no payment is due."

Response Submitted by: Texas Mutual Insurance Company, 6210 E. Highway 290, Austin, Texas 78723

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 12, 2010	CPT Code 99283	\$91.65	\$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for health care providers to pursue a medical fee dispute.
2. 28 Texas Administrative Code §133.20 sets out the procedures for health care providers to submit workers' compensation medical bills for reimbursement.
3. 28 Texas Administrative Code §102.4 sets out the rules for Non-Commission Communications.
4. Texas Labor Code §408.027 sets out the rules for timely submission of a claim by a health care provider.
5. Texas Labor Code §408.0272 sets out the rules for certain exceptions for untimely submission of a claim by a health care provider.
6. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits dated September 8, 2011

- CAC-29 – THE TIME LIMIT FOR FILING HAS EXPIRED.
- 731 – PER 133.20 PROVIDER SHALL NOT SUBMIT A MEDICAL BILL LATER THAN THE 95TH DAY AFTER THE DATE THE SERVICE, FOR SERVICES ON OR AFTER 9/1/05.

Explanation of benefits dated October 11, 2011

- CAC-193 – ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. UPON REVIEW, IT WAS DETERMINED THAT THIS CLAIM WAS PROCESSED PROPERLY.
- CAC-29 – THE TIME LIMIT FOR FILING HAS EXPIRED.
- 724 – NO ADDITIONAL PAYMENT AFTER A RECONSIDERATION OF SERVICES. FOR INFORMATION CALL 1-800-937-6824
- 731 – PER 133.20 PROVIDER SHALL NOT SUBMIT A MEDICAL BILL LATER THAN THE 95TH DAY AFTER THE DATE THE SERVICE, FOR SERVICES ON OR AFTER 9/1/05.

Issues

1. Did the requestor submit the medical bill for the services in dispute timely and in accordance with 28 Texas Administrative Code §133.20?
2. Did the requestor submit documentation to support the disputed bills were submitted timely in accordance with Texas Labor Code §408.027 and 28 Texas Administrative Code §102.4?
3. Did the requestor waive their right to reimbursement?

Findings

1. 28 Texas Administrative Code §133.20(b) states in pertinent part "Except as provided in Texas Labor Code §408.0272...a health care provider shall not submit a medical bill later than the 95th day after the date the services are provided." No documentation was found to support that Texas Labor Code §408.0272 applies to the service in dispute. Therefore, Texas Labor Code §408.0272 does not apply to the service in dispute, for that reason, the requestor in this dispute was required to send the medical bill no later than 95 days after the service in dispute was provided. 28 Texas Administrative Code §102.4(h) states "Unless the great weight of evidence indicates otherwise, written communications shall be deemed to have been sent on: (1) the date received, if sent by fax, personal delivery, or electronic transmission or, (2) the date postmarked if sent by mail via United States Postal Service regular mail, or, if the postmark date is unavailable, the later of the signature date on the written communication or the date it was received minus five days. If the date received minus five days is a Sunday or legal holiday, the date deemed sent shall be the next previous day which is not a Sunday or legal holiday."
2. Review of the requestor's submitted documentation finds one copy of the medical bill with printed date November 12, 2011, two Explanation of Benefits dated, September 8, 2011 and October 11, 2011, and a copy of a letter from the respondent dated July 19, 2011 requesting the requestor submit bill on proper CMS 1500 form. No documentation was found to sufficiently support that a medical bill was submitted to the correct insurance carrier within 95 days from the date the services were provided.
3. In accordance with Texas Labor Code §408.027, the Requestor in this medical fee dispute has forfeited the right to reimbursement due to untimely submission of the medical bill for the services in dispute.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that reimbursement is due. As a result, the amount ordered is \$0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the disputed services.

Authorized Signature

_____	_____	January 31, 2012
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision* together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party.****

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.